

		FOR BHF USE					

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2005
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2005)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION
THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY
PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE
OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE
ANY INFORMATION ON OR BEFORE THE DUE DATE WILL
RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM
HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0042853

Facility Name: Highland Health Care Center

Address: 1450 - 26th Street Highland 62249
Number City Zip Code

County: Madison

Telephone Number: (618) 654-2368 Fax # (618) 654-4741

HFS ID Number: 330748151003

Date of Initial License for Current Owners: 6/1/92

Type of Ownership:

<input type="checkbox"/>	VOLUNTARY,NON-PROFIT	<input checked="" type="checkbox"/>	PROPRIETARY	<input type="checkbox"/>	GOVERNMENTAL
<input type="checkbox"/>	Charitable Corp.	<input type="checkbox"/>	Individual	<input type="checkbox"/>	State
<input type="checkbox"/>	Trust	<input type="checkbox"/>	Partnership	<input type="checkbox"/>	County
IRS Exemption Code		<input checked="" type="checkbox"/>	Corporation	<input type="checkbox"/>	Other
		<input type="checkbox"/>	"Sub-S" Corp.		
		<input type="checkbox"/>	Limited Liability Co.		
		<input type="checkbox"/>	Trust		
		<input type="checkbox"/>	Other		

In the event there are further questions about this report, please contact:
Name: Cathy Storr Telephone Number: (714) 689-0300

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the
State of Illinois, for the period from 1/1/05 to 12/31/05
and certify to the best of my knowledge and belief that the said contents
are true, accurate and complete statements in accordance with
applicable instructions. Declaration of preparer (other than provider)
is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information
in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider	(Signed)		(Date)	
	(Type or Print Name)			
	(Title)			
Paid Preparer	(Signed)		(Date)	
	(Print Name and Title)	Cathy Storr Principal		
	(Firm Name & Address)	Kellogg & Andelson Accountancy Corporation 3200 Park Center Drive Suite 750 Costa Mesa, CA 92626		
	(Telephone)	(714) 689-0300	Fax #	(714) 689-0311
	MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630			

Facility Name & ID Number Highland Health Care Center

0042853 Report Period Beginning: 1/1/05 Ending: 12/31/05

III. STATISTICAL DATA					
A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____					
	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	50	Skilled (SNF)	50	18,250	1
2		Skilled Pediatric (SNF/PED)			2
3	78	Intermediate (ICF)	78	28,470	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	128	TOTALS	128	46,720	7

B. Census-For the entire report period.						
	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	16,408	3,413	5,707	25,528	8
9	SNF/PED					9
10	ICF	8,394	3,526	31	11,951	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	24,802	6,939	5,738	37,479	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 80.22%

D. How many bed-hold days during this year were paid by the Department?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
n/a

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES ☐ NO ☒

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES ☒ NO ☐

I. On what date did you start providing long term care at this location?
Date started 2/1/64

J. Was the facility purchased or leased after January 1, 1978?
YES ☒ Date 4/1/97 NO ☐

K. Was the facility certified for Medicare during the reporting year?
YES ☒ NO ☐ If YES, enter number of beds certified 50 and days of care provided 5,287

Medicare Intermediary AdminaStar Federal

IV. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED CASH* ☐ CASH* ☐

Is your fiscal year identical to your tax year? YES ☒ NO ☐

Tax Year: 12/31/05 Fiscal Year: 12/31/05

* All facilities other than governmental must report on the accrual basis.

STATE OF ILLINOIS

Page 3

Facility Name & ID Number Highland Health Care Center # 0042853 Report Period Beginning: 1/1/05 Ending: 12/31/05

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary	190,735	26,756	15,013	232,504		232,504	(1,046)	231,458			1
2	Food Purchase		143,268		143,268		143,268		143,268			2
3	Housekeeping	96,547	13,586	17,657	127,790		127,790		127,790			3
4	Laundry	79,249	13,979	1,479	94,707		94,707		94,707			4
5	Heat and Other Utilities			96,878	96,878		96,878		96,878			5
6	Maintenance	60,998	8,594	17,407	86,999		86,999		86,999			6
7	Other (specify):*											7
8	TOTAL General Services	427,529	206,183	148,434	782,146		782,146	(1,046)	781,100			8
	B. Health Care and Programs											
9	Medical Director			12,000	12,000		12,000		12,000			9
10	Nursing and Medical Records	1,614,126	94,238	33,317	1,741,681		1,741,681		1,741,681			10
10a	Therapy		2,110	436,280	438,390		438,390	33,954	472,344			10a
11	Activities	68,151	5,426	4,233	77,810		77,810		77,810			11
12	Social Services	36,156	25	1,821	38,002		38,002		38,002			12
13	CNA Training											13
14	Program Transportation	18,756		4,868	23,624		23,624		23,624			14
15	Other (specify):*							20,996	20,996			15
16	TOTAL Health Care and Programs	1,737,189	101,799	492,519	2,331,507		2,331,507	54,950	2,386,457			16
	C. General Administration											
17	Administrative	96,384		277,800	374,184		374,184	(84,366)	289,818			17
18	Directors Fees											18
19	Professional Services											19
20	Dues, Fees, Subscriptions & Promotions			863	863		863	(863)				20
21	Clerical & General Office Expenses	172,924	6,936	143,430	323,290		323,290	(82,111)	241,179			21
22	Employee Benefits & Payroll Taxes			561,673	561,673		561,673		561,673			22
23	Inservice Training & Education											23
24	Travel and Seminar			15,613	15,613		15,613		15,613			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			81,412	81,412		81,412		81,412			26
27	Other (specify):*											27
28	TOTAL General Administration	269,308	6,936	1,080,791	1,357,035		1,357,035	(167,340)	1,189,695			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,434,026	314,918	1,721,744	4,470,688		4,470,688	(113,436)	4,357,252			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			41,255	41,255		41,255	1,721	42,976			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			39,309	39,309		39,309	(35,385)	3,924			32
33	Real Estate Taxes			62,855	62,855		62,855		62,855			33
34	Rent-Facility & Grounds			420,393	420,393		420,393		420,393			34
35	Rent-Equipment & Vehicles			10,631	10,631		10,631		10,631			35
36	Other (specify):*							20,983	20,983			36
37	TOTAL Ownership			574,443	574,443		574,443	(12,681)	561,762			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		200,249	10,415	210,664		210,664		210,664			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			70,080	70,080		70,080		70,080			42
43	Other (specify):*		41,390		41,390		41,390		41,390			43
44	TOTAL Special Cost Centers		241,639	80,495	322,134		322,134		322,134			44
	GRAND TOTAL COST											
45	(sum of lines 29, 37 & 44)	2,434,026	556,557	2,376,682	5,367,265		5,367,265	(126,117)	5,241,148			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

VI. ADJUSTMENT DETAIL A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer-	OHF USE	
			ence	ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(1,046)	1		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(119)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(964)	21		13
14	Non-Care Related Interest	(35,266)	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(42,238)	21		24
25	Fund Raising, Advertising and Promotional	(9,074)	21		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(45,785)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (134,492)		\$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	8,375		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 8,375		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (126,117)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1	2	3	4	
		Yes	No	Amount	Reference	
38	Medically Necessary Transport.		X	\$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

NON-ALLOWABLE EXPENSES		Sch. V Line	
	Amount	Reference	
1	Dues and Subscriptions	\$ (863)	20 1
2	Bank Charges	(592)	21 2
3	Public Relations	(8,699)	21 3
4	Patient Theft and Loss	(13)	21 4
5	Prior Year Expense	(2,697)	21 5
6	Barber Revenue	(1,172)	21 6
7	Personal Items	(2,043)	21 7
8	Other Revenue	(843)	21 8
9	Prior Year Revenue	(13,776)	21 9
10	Depreciation Reconciliation	1,721	30 10
11	Bonus Overaccrual	(16,808)	17 11
12	Director of Nursing Bonus	0	17 12
13	Director of Nursing Bonus	0	10 13
14			14
15			15
16			16
17			17
18			18
19			19
20			20
21			21
22			22
23			23
24			24
25			25
26			26
27			27
28			28
29			29
30			30
31			31
32			32
33			33
34			34
35			35
36			36
37			37
38			38
39			39
40			40
41			41
42			42
43			43
44			44
45			45
46			46
47			47
48			48
49	Total	(45,785)	49

Summary A

12/31/05

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

[illegible]

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary

1OWNERS		2RELATED NURSING HOMES		3OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Covenant Care Inc.	100%	see attached		see attached		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES

☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1Schedule V		2Line	3Cost Per General LedgerItem	4Amount	5Cost to Related OrganizationName of Related Organization	6Percent of Ownership	7Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	15	HO Alloc Direct Care	\$	Covenant Care Inc.	100.00%	\$ 20,996	\$ 20,996	1
2	V	17	HO Alloc Indirect Care	277,800	Covenant Care Inc.	100.00%	210,242	(67,558)	2
3	V	36	HO Alloc Capital Amount		Covenant Care Inc.	100.00%	20,983	20,983	3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$ 277,800			\$ 252,221	\$ * (25,579)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES

☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	10a	Physical Therapy	\$272,080	Select Therapy		\$294,394	\$22,314	15
16	V	10a	Occupational Therapy	91,024	Select Therapy		98,489	7,465	16
17	V	10a	Speech Therapy	50,914	Select Therapy		55,089	4,175	17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$414,018			\$447,972	\$*33,954	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	n/a								\$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees).
FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME
ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Highland Health Care Center # 0042853 Report Period Beginning: 1/1/05 Ending: 12/31/05

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization Covenant Care Inc.
Street Address 27071 Aliso Creek Road
City / State / Zip Code Aliso Viejo, CA 92656
Phone Number (949) 349-1200
Fax Number (949) 349-1900

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	15	HO Alloc.-Direct Care	accumulated cost			\$	\$		\$ 20,996	1
2	17	HO Alloc.-Indirect Care	accumulated cost						210,242	2
3	36	HO Alloc.-Capital Amount	accumulated cost						20,983	3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$ 252,221	25

Facility Name & ID Number Highland Health Care Center # 0042853 Report Period Beginning: 1/1/05 Ending: 12/31/05

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES X NO

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization Select Therapy
Street Address 27071 Aliso Creek Road
City / State / Zip Code Aliso Viejo, CA 92656
Phone Number (949) 349-1200
Fax Number (949) 349-1900

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
	1	10a Physical Therapy				\$	\$		\$ 294,394	1
	2	10a Occupational Therapy							98,489	2
	3	10a Speech Therapy							55,089	3
	4									4
	5									5
	6									6
	7									7
	8									8
	9									9
	10									10
	11									11
	12									12
	13									13
	14									14
	15									15
	16									16
	17									17
	18									18
	19									19
	20									20
	21									21
	22									22
	23									23
	24									24
	25	TOTALS				\$	\$		\$ 447,972	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1	Banque Paribas		X	Purchase of facility		2/3/98	\$ 752,000	\$ (658,000)		various	\$ 39,309	1	
2	Less: non-care interest										(35,266)	2	
3												3	
4												4	
5												5	
	Working Capital												
6												6	
7												7	
8												8	
9	TOTAL Facility Related						\$ 752,000	\$ (658,000)			\$ 4,043	9	
	B. Non-Facility Related*												
10												10	
11	Interest Income										(119)	11	
12												12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$ (119)	14	
15	TOTALS (line 9+line14)						\$ 752,000	\$ (658,000)			\$ 3,924	15	

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ n/a Line #

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.
(See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.
(See instructions.)

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

		Important , please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.			
1. Real Estate Tax accrual used on 2004 report.				\$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)				\$	62,855 2
3. Under or (over) accrual (line 2 minus line 1).				\$	62,855 3
4. Real Estate Tax accrual used for 2005 report. (Detail and explain your calculation of this accrual on the lines below.)				\$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)				\$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)				\$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.				\$	62,855 7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:		2000	49,800	8	
		2001	48,931	9	
		2002	51,094	10	
		2003	54,381	11	
		2004	57,872	12	
				FOR OHF USE ONLY	
				13	FROM R. E. TAX STATEMENT FOR 2004 \$ 13
				14	PLUS APPEAL COST FROM LINE 5 \$ 14
				15	LESS REFUND FROM LINE 6 \$ 15
				16	AMOUNT TO USE FOR RATE CALCULATION \$ 16

- NOTES:
1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.

2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates RE: 2004 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2004 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2004.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2004 real estate tax bill to the Department of Public Aid, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2005 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions,

2004 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Highland Health Care Center COUNTY Madison

FACILITY IDPH LICENSE NUMBER 0042853

CONTACT PERSON REGARDING THIS REPORT Cathy Storr

TELEPHONE (714) 689-0300 FAX #: (714) 689-0311

A. Summary of Real Estate Tax Cos

Enter the tax index number and real estate tax assessed for 2004 on the lines provided below. Enter only the portion of tl cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursir home property which is vacant, rented to other organizations, or used for purposes other than long term care must not l entered in Column D. Do not include cost for any period other than calendar year 2004

	(A)	(B)	(C)	(D)
	<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
1.	01-2-24-08-08-201-004	Long Term Care	\$ 57,872.49	\$ 57,872.49
2.			\$	\$
3.			\$	\$
4.			\$	\$
5.			\$	\$
6.			\$	\$
7.			\$	\$
8.			\$	\$
9.			\$	\$
10.			\$	\$
		TOTALS	\$ 57,872.49	\$ 57,872.49

B. Real Estate Tax Cost Allocation:

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not direct used for nursing home services' YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing hom (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used

C. Tax Bills

Attach a copy of the original 2004 tax bills which were listed in Section A to this statement. Be sure to use the 200 tax bill which is normally paid during 2005

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 21,432 B. General Construction Type: Exterior Frame Number of Stories 1

C. Does the Operating Entity? (a) Own the Facility (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? (a) Own the Equipment (b) Rent equipment from a Related Organization. (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

none

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? YES NO

If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

		1	2	3	4	
A. Land.		Use	Square Feet	Year Acquired	Cost	
1					\$	1
2						2
3	TOTALS				\$	3

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	various			1994	5,613		5			5,613	9
10	various			1995	6,998		5			6,998	10
11	various			1996	4,048		5			4,048	11
12	various			1997	8,482		5			8,482	12
13	various			1998	22,969		5			22,969	13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37		\$	\$		\$	\$	\$	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67								67
68	Related Party Allocations							68
69	Financial Statement Depreciation		15,510			(15,510)		69
70	TOTAL (lines 4 thru 69)	\$ 48,110	\$ 15,510		\$	\$ (15,510)	\$ 48,110	70

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 48,110	\$ 15,510		\$	\$ (15,510)	\$ 48,110	1
2	Wallpaper	1999	2,310		5			2,310	2
3	Temperature Control unit anit-scald valve (2 each)	1999	636		5			636	3
4	Oxygen Shed installation hardware	1999	84		5			83	4
5	Water Heater- 91 gallon	1999	3,346		5			3,345	5
6	Hot Water Heater	1999	2,359		5			2,359	6
7	Draperies, cubical curtains, bedspreads	1999	14,407		5			14,407	7
8	TV Wall Mount 221 x131	1999	65		5			65	8
9	Renovation Design & Construction - Patio	1999	28,138		5			28,138	9
10	Installed Pyro Chem Fire Suppression System	1999	1,591		5			1,591	10
11	Renovation Design & Construction - Patio	1999	29,635		5			29,635	11
12	Concrete and supplies	1999	309		5			309	12
13	Repairs to roof and interior damage	1999	2,620		5			2,620	13
14	Hanging cubicle curtains	1999	149		5			149	14
15	Cubical curtains & bedspreads	1999	6,314		5			6,314	15
16	Renovation of Activities Room (slats & vein savers)	1999	435		5			435	16
17	Fire Alarm 50%	1999	18,589		5			18,589	17
18	Circulating Pump	1999	2,050		5			2,050	18
19	Fire Alarm System	2000	17,441		5	291	291	17,441	19
20	Repairs to roof- reclassified from CIP	2000	95,515		5	3,184	3,184	95,515	20
21	Kemper claim check no. 019-0-808-173	2000	(92,940)		5	(3,098)	(3,098)	(92,940)	21
22	Install Fire Alarm system	2000	1,056		5	53	53	1,056	22
23	Renovation Design & Construction of Alzheimer's Unit	2000	1,765		5	88	88	1,765	23
24	Balance on fire alarm system from 1/00	2000	4,003		5	267	267	4,003	24
25	Paint exterior of bulding	2000	497		5	33	33	497	25
26	roof drains	2000	1,680		5	112	112	1,680	26
27	compressor in "B" hall air conditioner	2000	823		5	82	82	823	27
28	10 GE Air Conditioners	2000	5,272		5	527	527	5,272	28
29	shelves & coutertops (front office & nurse's stations)	2001	3,732		5	760	760	3,732	29
30	shelves & coutertops (front office & nurse's stations)	2001	158		5	32	32	158	30
31	shelves & coutertops (front office & nurse's stations)	2001	100		5	20	20	100	31
32	front main door	2001	627		5	128	128	627	32
33	carpet for front office & nurse's station	2001	445		5	92	92	445	33
34	TOTAL (lines 1 thru 33)		\$ 201,321	\$ 15,510		\$ 2,571	\$ (12,939)	\$ 201,319	34

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 201,321	\$ 15,510		\$ 2,571	\$ (12,939)	\$ 201,319	1
2	Carpet for front office & nurses station	2001	328		5	68	68	328	2
3	Wall cap counter	2001	610		5	141	141	610	3
4	Door alarm system	2001	3,220		5	758	758	3,220	4
5	Water Heater (serve E,F,A,B Halls)	2001	3,014		5	738	738	3,014	5
6	New door locking device	2001	948		5	232	232	948	6
7	Bath tub	2001	7,908		5	1,977	1,977	7,908	7
8	Plumbing accessories	2002	772		5	206	206	772	8
9	Plumbing accessories	2002	1,033		5	276	276	1,033	9
10	Wallpaper for Therapy Room	2002	405		5	110	110	405	10
11	30" Tub	2002	147		5	43	43	147	11
12	3 ton A/C	2002	1,799		5	527	527	1,799	12
13	Nurses Station Countertops	2002	1,060		5	318	318	1,060	13
14	Seal Coat Lot	2002	978		5	309	309	978	14
15									15
16	Fire Board Replacement	2003	1,678		5	464	464	1,678	16
17	Therapy Room Remodeling	2003	2,896		5	1,241	1,241	2,896	17
18	Reno Walk-In Cooler	2003	1,059		5	454	454	1,059	18
19	Remodel OP Therapy	2003	2,824		5	1,210	1,210	2,824	19
20	Heating/Air Conditioning Unit	2003	751		5	150	150	300	20
21	Replace Sprinkler Heads	2004	1,610		5	322	322	590	21
22	New Carpet	2004	708		5	142	142	248	22
23	Repairs on Compressor	2004	1,126		5	225	225	263	23
24									24
25	Repair/replace sidewalks	2005	5,780		5	867	867	867	25
26	Repair/replace sidewalks	2005	5,711		5	666	666	666	26
27	Repair/replace sidewalks	2005	1,579		5	184	184	184	27
28	Repair/replace sidewalks	2005	891		5	89	89	89	28
29	Repair/replace sidewalks	2005	5,204		5	520	520	520	29
30	Repair/replace sidewalks	2005	998		5	100	100	100	30
31	36 window replacements	2005	9,000		5	300	300	300	31
32	Balance due for window replacements	2005	8,718		5	291	291	291	32
33	Remodel bed ward-Alzheimers unit	2005	19		20				33
34	TOTAL (lines 1 thru 33)		\$ 274,095	\$ 15,510		\$ 15,499	\$ (11)	\$ 236,416	34

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 274,095	\$ 15,510		\$ 15,499	\$ (11)	\$ 236,416	1
2	Remodel bed ward-Alzheimers unit	2005	117		20				2
3	Remodel bed ward-Alzheimers unit	2005	365		20	2	2	2	3
4	Remodel bed ward-Alzheimers unit	2005	194		20	1	1	4	4
5	Reno utility room	2005	186		20	1	1	4	5
6	Reno utility room	2005	237		20	1	1	4	6
7	Reno utility room	2005	901		20	4	4	4	7
8	Reno utility room	2005	339		20	1	1	1	8
9	Reno utility room	2005	161		20	1	1	1	9
10	Reno utility room	2005	75		20				10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 276,670	\$ 15,510		\$ 15,510	\$	\$ 236,436	34

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 136,671	\$ 23,177	\$ 23,177	\$	10	\$ 236,388	71
72	Current Year Purchases	33,063	4,720	4,720		10	4,720	72
73	Fully Depreciated Assets	143,598				10	143,598	73
74								74
75	TOTALS	\$ 313,332	\$ 27,896	\$ 27,896	\$		\$ 384,706	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Transportation	1994 Ford Wagon	1994	\$ 26,845	\$ (430)	\$ (430)	\$	5	\$ 0	76
77										77
78										78
79										79
80	TOTALS			\$ 26,845	\$ (430)	\$ (430)	\$		\$ 0	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 616,847	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 42,976	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 42,976	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 621,142	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92	Construction in progress '02-'04	18,398	92
93	Construction in progress '05	74,584	93
94			94
95		\$ 92,982	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: Highland Leasehold, Inc.
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions.
- ☐ YES
- ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions				420,393			4
5								5
6								6
7	TOTAL				\$ 420,393			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease
-
-

9. Option to Buy:
- ☐ YES
- ☒ NO
- Terms:
- *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental?
- ☐ YES
- ☒ NO
16. Rental Amount for movable equipment: \$ 10,631
- Description: see supplemental schedule 14.1
- (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

10. Effective dates of current rental agreement:
- Beginning 4/1/97
- Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2006	\$
13.	/2007	\$
14.	/2008	\$

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

☐ YES

☒ NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM☐

IN OTHER FACILITY☐

COMMUNITY COLLEGE☐

HOURS PER CNA

3. CLINICAL PORTION:

IN-HOUSE PROGRAM☐

IN OTHER FACILITY☐

HOURS PER CNA

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

\$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.

(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.

(c) For in-house training programs only. Do not include fringe benefits.

(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.

(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

12345678										
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	10a-3	hrs	\$		\$ 91,024	\$		\$ 91,024	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a-3	hrs			273,080			273,080	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39	# of prescripts				210,664		210,664	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			\$		\$ 364,104	\$ 210,664		\$ 574,768	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$1,600	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	(63,724)		3
4	Supply Inventory (priced at)	56,331		4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	4,306		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See attached schedule 17.1	21,425		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$19,938	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	284,432		15
16	Equipment, at Historical Cost	313,332		16
17	Accumulated Depreciation (book methods)	(477,537)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	313,317		19
	Accumulated Amortization -			
20	Organization & Pre-Operating Costs	(56,658)		20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See attached schedule 17.1	200,915		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$577,801	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$597,739	\$	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$1,444	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	88,670		30
	Accrued Taxes Payable			
31	(excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See attached schedule 17.1	470,918		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$561,032	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See attached schedule 17.1	658,000		43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$658,000	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$1,219,032	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$(621,293)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$597,739	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (223,138)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (223,138)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(398,155)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (398,155)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ (621,293)	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Highland Health Care Center # 0042853 Report Period Beginning: 1/1/05 Ending: 12/31/05

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.
Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 4,878,923	1
2	Discounts and Allowances for all Levels	(1,748,056)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,130,867	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,005,795	6
7	Oxygen	5,265	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,011,060	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	1,172	13
14	Non-Patient Meals	1,047	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	491,850	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	74,713	19
20	Radiology and X-Ray	23,720	20
21	Other Medical Services	217,900	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 810,402	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	119	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 119	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See attached schedule 19.1	16,662	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 16,662	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 4,969,110	30

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	782,146	31
32	Health Care	2,331,507	32
33	General Administration	1,357,036	33
	B. Capital Expense		
34	Ownership	574,443	34
	C. Ancillary Expense		
35	Special Cost Centers	252,054	35
36	Provider Participation Fee	70,080	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 5,367,265	40
41	Income before Income Taxes (line 30 minus line 40)**	(398,155)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (398,155)	43

* This must agree with page 4, line 45, column 4.

** Does this agree with taxable income (loss) per Federal Income Tax Return? If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,964	2,020	\$ 66,596	\$ 32.97	1
2	Assistant Director of Nursing	1,866	1,866	46,814	25.09	2
3	Registered Nurses	17,943	18,221	381,965	20.96	3
4	Licensed Practical Nurses	15,328	15,565	286,175	18.39	4
5	CNAs & Orderlies	68,525	69,586	824,665	11.85	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	5,924	6,093	68,151	11.19	10
11	Social Service Workers	3,564	3,615	36,156	10.00	11
12	Dietician					12
13	Food Service Supervisor	1,791	1,791	24,484	13.67	13
14	Head Cook					14
15	Cook Helpers/Assistants	18,666	19,336	166,251	8.60	15
16	Dishwashers					16
17	Maintenance Workers	3,803	3,851	60,998	15.84	17
18	Housekeepers	10,165	10,387	96,547	9.29	18
19	Laundry	7,988	8,145	79,249	9.73	19
20	Administrator					20
21	Assistant Administrator					21
22	Other Administrative	2,016	2,016	96,384	47.81	22
23	Office Manager					23
24	Clerical	7,670	7,746	130,937	16.90	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,830	1,838	25,561	13.91	31
32	Other Health CaCentral Supply	1,914	1,949	24,338	12.49	32
33	Other(specify)	1,875	1,875	18,755	10.00	33
34	TOTAL (lines 1 - 33)	172,832	175,900	\$ 2,434,026 *	\$ 13.84	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	216+mileage	\$ 8,379		35
36	Medical Director	monthly	12,000		36
37	Medical Records Consultant	22	860		37
38	Nurse Consultant				38
39	Pharmacist Consultant	monthly	4,078		39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	33+mileage	1,942		44
45	Social Service Consultant	28+mileage	1,821		45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	22	\$ 29,080		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$		50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)		\$		53

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description		Amount	Description	Amount
Robert McDonald (1/1/05-12/31/05)	Administrator		\$ 96,384	Workers' Compensation Insurance	\$	74,019	IDPH License Fee	\$
				Unemployment Compensation Insurance		34,617	Advertising: Employee Recruitment	
				FICA Taxes		180,012	Health Care Worker Background Check	
				Employee Health Insurance		261,974	(Indicate # of checks performed)	
				Employee Meals			Dues and Subscriptions	863
				Illinois Municipal Retirement Fund (IMRF)*				
				401K/Other		11,051		
TOTAL (agree to Schedule V, line 17, col. 1)								
(List each licensed administrator separately.)			\$ 96,384					
B. Administrative - Other							Less: Dues and Subscriptions	(863)
Description			Amount				Less: Public Relations Expense	()
Management Fees- Covenant Care Inc.			\$ 277,800				Non-allowable advertising	()
							Yellow page advertising	()
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 277,800	TOTAL (agree to Schedule V, line 22, col.8)			TOTAL (agree to Sch. V, line 20, col. 8)	
(Attach a copy of any management service agreement)					\$	561,673		
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount
			\$ 0				Out-of-State Travel	\$ 5,224
							In-State Travel	9,230
							Seminar Expense	1,159
							Entertainment Expense	()
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL			(agree to Sch. V, line 24, col. 8)	
(If total legal fees exceed \$2500 attach copy of invoices.)			\$				TOTAL	\$ 15,613

* Attach copy of IMRF notifications

**See instructions.

(See instructions.)

[illegible]

Facility Name & ID Number Highland Health Care Center

0042853

Report Period Beginning:

1/1/05

Ending:

12/31/05

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? No
If YES, give association name and amount. _____
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? _____
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? yes
What was the average life used for new equipment added during this period? 5 years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 94 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation. _____
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. _____
- (9) Are you presently operating under a sublease agreement? _____ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 70,080
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation. _____
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 0 Has any meal income been offset against related costs? No Indicate the amount. \$ _____
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? Yes
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? None
d. Have vehicle usage logs been maintained? Yes
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? n/a
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ _____
- (17) Has an audit been performed by an independent certified public accounting firm? _____
Firm Name: Ernst & Young The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? No If no, please explain. Audit not specific to facility
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? n/a
Attach invoices and a summary of services for all architect and appraisal fees.

STATE OF ILLINOIS

Facility Name: Highland Health Care Center
ID# State Fac. # 0042853

Report Period: Beginning: 1/1/2005
Ending: 12/31/2005

SUPPLEMENTAL SCHEDULE OF OTHER EXPENSES

<u>Operating Expenses - Line 7</u>	<u>Amount</u>
Not Applicable	
	<u>0</u>
<u>Other (specify) - Line 15</u>	<u>Amount</u>
HO Alloc Direct Care	20,996
	<u>20,996</u>
<u>Health Care Programs - Line 16</u>	<u>Amount</u>
Not Applicable	
	<u>0</u>
<u>General & Administrative - Line 27</u>	<u>Amount</u>
Not Applicable	
	<u>0</u>
<u>Inservice Education - Line 23 - Use if more than \$2,000</u>	<u>Amount</u>
	<u>0</u>

STATE OF ILLINOIS

Facility Name: Highland Health Care Center
ID# State Fac. # 0042853

Report Period: Beginning: 1/1/2005
Ending: 12/31/2005

SUPPLEMENTAL SCHEDULE OF OTHER EXPENSES

<u>Ownership Costs - Line 36</u>	<u>Amount</u>
HO Alloc Capital Amount	20,983

Total Page 4 / Line 36 / Column 8 ----->	<u>20,983</u>
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<u>Special Cost Centers - Line 43</u>	<u>Amount</u>
LABORATORY PURCHASED SERVICES 840060000700	22,970
RADIOLOGY PURCHASED SERVICES 891060000700	18,420

Total Page 4 / Line 43 / Column 8 ----->	<u>41,390</u>
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Highland Health Care Center

STATE OF ILLINOIS ID: State Fac. # 0042853

PAGE 14 - EQUIPME State Fac. # 0042853

REPORTING PERIOD: Beginning: 1/1/2005 Ending: 12/31/2005

Lease Expense - Non-Medical Equipment	-
Lease Expense - Vehicles	10,631

TOTAL	<div>10,631</div>
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Reconcile with schedule V, line 35, column 8:	<div>10,631</div>	(page 4, line 35, col 8)
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DIFFERENCE	<div>-</div>
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STATE OF ILLINOIS

Facility Name: Highland Health Care Center
ID# State Fac. # 0042853

Report Period: Beginning: 1/1/2005
Ending: 12/31/2005

SUPPLEMENTAL SCHEDULE OF MEDICAL SUPPLIES

Special Services - Supplies (Line 13 / Column 6 - Other)

Amount

0

Outside: Therapies (Line 13 / Column 5 - Other)

Amount

0

STATE OF ILLINOIS

Facility Name: Highland Health Care Center
ID# State Fac. # 0042853

Report Period: Beginning: 1/1/2005
Ending: 12/31/2005

SUPPLEMENTAL SCHEDULE OF OTHER ASSETS & LIABILITIES

OTHER CURRENT ASSETS:	AMOUNT	
PLEDGES & REC - OTHER RECEIVABLES	21,425	
TOTAL	21,425	Difference
Reconcile with schedule XV, line 9:	21,425	0

OTHER NON-CURRENT ASSETS:		
CONSTRUCTION-IN-PROGRESS	149,329	
DEPOSITS - LEASES	50,434	
HOLIDAY FUND	1,152	
	200,915	Difference
Reconcile with schedule XV, line 23:	200,915	0

OTHER CURRENT LIABILITIES:	AMOUNT	
OTHR DEFRRD CRED - DEFERRED RENT	-40,849	
	-40,849	Difference
Reconcile with schedule XV, line 36:	40,849	0

OTHER NON-CURRENT LIABILITIES:		
OTHR NONCURR - BANQUE PARIBAS-SR DEBT	-658,000	
	-658,000	Difference
Reconcile with schedule XV, line 43:	658,000	0

STATE OF ILLINOIS

Facility Name: Highland Health Care Center
ID# State Fac. # 0042853

Report Period: Beginning: 1/1/2005
Ending: 12/31/2005

SUPPLEMENTAL SCHEDULE OF REVENUES

DESCRIPTION		Amount		
MISC. REV. PERSONAL ITEMS	800040003250	-2,043		
MISC. REV. VENDING MACHINE	800040003340	0		
MISC. REV. OTHER REVENUE	800040003400	-843		
MISC. REV. PRIOR YEAR REVENUE	800052003520	-13,776		
			Total from Schedule XVII, line 28	Difference
	TOTALS	-16,662	-16,662	0
DESCRIPTION		Amount		
		0		
		0		
		0		
		0		
		0		
			Total from Schedule XVII, line 28a	Difference
	TOTALS	0	0	0

Highland Health Care Center
STATE OF ILLINOIS ID:
PROVIDER PARTICIPAState Fac. # 0042853
REPORTING PERIOD: Beginning: 1/1/2005 Ending: 12/31/2005

PROVIDER PARTICIPATION FEE PER WTB (schedule V, line 42, Column 8)	70,080
46720 BED DAYS X \$1.50 (128 Beds X 365 Days)	70,080
UNDETAILED AMOUNT	<div>-</div>